LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON VOLUNTARY ASSISTED DYING BILL
Ms Suzanne Orr MLA (Chair), Ms Leanne Castley (Deputy Chair),
Mr Andrew Braddock MLA, Mr Ed Cocks MLA, Dr Marisa Paterson MLA

Submission Cover Sheet

Inquiry into the Voluntary Assisted Dying Bill 2023

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Calvary

Hospitals
Home Care
Virtual Care
Retirement Living
Residential Aged Care

8 December 2023

Select Committee on the Voluntary Assisted Dying (VAD) Bill 2023
Office of the Legislative Assembly for the ACT

Submission to the Legislative Assembly Select Committee on the Voluntary Assisted Dying (VAD) Bill 2023

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Introductory remarks

Calvary thanks the Select Committee for the opportunity to provide feedback on the *Voluntary Assisted Dying Bill 2023* (ACT). Since the establishment of Calvary in 1885, with the arrival of the Sisters of the Little Company of Mary in Australia, Calvary has cared for people at the end of their lives. Today, we continue to provide high quality palliative and end-of-life care.

Calvary assists people to die in comfort and with dignity and will continue to provide this assistance to anyone who is dying, whilst in Calvary's care, if the Bill becomes law. Calvary cannot, however, and will not, support or provide for the administration of a substance that will objectively, directly and intentionally bring about a person's death as *the* means to relieve suffering.

Calvary can, and will, seek to relieve a person's suffering (recognising this suffering can be physical, psychological, existential, spiritual or even anticipatory) in order to maximise their experience of the life they continue to have. Calvary knows that experience of dying is mostly living and we support people to make that experience of living as full and meaningful as possible.

Calvary has a number of concerns about this Bill, both regarding VAD itself and regarding the particular VAD framework the Bill proposes. Calvary's stance regarding VAD is well-known and well-documented. Reiterating this stance is not the primary purpose of this submission. Instead, Calvary seeks to outline our concerns regarding the proposed VAD framework, with particular reference to how it differs from the VAD model in NSW and other Australian jurisdictions.

The Bill does not provide a definition for 'voluntary assisted dying' but the ACT Government has previously described it as "a safe and effective medical process that gives an eligible person the option to end their suffering by choosing how and when they die."[1]

Nevertheless, on Thursday 30 November 2023, the Federal Court ruled that VAD is considered suicide under the *Criminal Code Act 1995 (*Cth). Federal Court Justice Wendy Abraham said in her ruling:

> *"Voluntary assisted dying, while a means carefully regulated and a societally approved means of a person intentionally taking their own life, remains a means of a person taking their own life."*

This is instructive. Calvary believes that any VAD model, i.e. a framework that allows a person to access the means of taking their own life, albeit in a regulated and societally approved manner, ought to be considered with extreme care.

Of particular concern to Calvary is the disparity between the model proposed for the ACT and the existing model in adjacent NSW. In the provision of healthcare services, there is substantial intersection between residents of the ACT and residents of NSW. This creates issues with respect to the workability of the Bill.

Calvary is also concerned about legislative overreach in requiring health practitioners to meet certain

[1] Voluntary Assisted Dying Discussion Paper, issued by: Justice & Community Safety Directorate in Conjunction with ACT Health Directorate and Canberra Health Services (hereafter referenced as "Discussion paper"), https://hdp-au-prod-app-act-yoursay-files.s3.ap-southeast-2.amazonaws.com/8416/7567/8207/Voluntary_assisted_dying_Discussion_Paper_PDF_version.pdf, 4.

obligations in relation to VAD, which is presented as a clinical procedure, that are not required of them in relation to any other clinical service. If a medical practitioner, or the facility in which they practice, does not provide neurosurgical services, they are not required to provide the contact details of neurosurgeon in writing within two working days. Why, then, is a health practitioner required to provide the contact details of the navigator service in writing within two working days? Similarly, a facility providing subacute services is not required to allow an external health practitioner, not credentialed by the facility operator, to enter the facility to provide neurosurgical services. There is an inconsistency here, which needs to be corrected. Consistency in practice and minimising variation is a better pathway to safety and quality.

Summary of changes submitted and recommendations

Whilst Calvary does not support the introduction of any VAD legislation, we are seeking changes to the Bill to align it with the NSW model, reducing confusion for residents of both jurisdictions.

Changes submitted:

1. Acknowledge a distinction, in the definitions listed in Clause 96, between facilities which provide services to permanent residents, such as residential aged facilities, and facilities which provide services to non-permanent residents, such as hospitals and hospices.
2. Regarding facilities, such as hospitals and hospices, which provide episodic care and services to exclusively non-permanent residents, align the Bill (Act) with the requirements of Division 3 Health care establishments (Sections 99-107) of the NSW legislation, including the following:
    a. Do not force non-participating facilities to allow external practitioners, who are not credentialed by the facility's operator, to enter the facility and provide VAD services, which are outside the facility's scope of practice. For example, the NSW legislation handles this by requiring the facility operator to take reasonable steps to facilitate the transfer of the person to and from a place where the person may access the formal steps of the VAD process.
    b. Permit non-participating facilities to make decisions about patient transfer in consultation with the treating medical practitioner, e.g. the medical practitioner credentialed by the facility's operator, and taking into account the considerations listed in Clause 101 (3)(a-e) of the Bill. This will align the Bill with the existing legislation in NSW.
3. Remove the requirement for the facility operator to provide the person with the contact details for the VAD navigator service *in writing* and align requirements regarding access to information about VAD with Sections 90 and 99 of the NSW legislation.
4. Specify the eligibility requirements for medical practitioners and nurse practitioners to act as authorised coordinating and consulting practitioners in the Bill (Act). This will alleviate concerns that regulations will subsequently be changed to allow other health practitioners to act in these roles.
5. Specify the eligibility requirements for medical practitioners, nurse practitioners and registered nurses to act as authorised administering practitioners in the Bill (Act). This will alleviate concerns that regulations will subsequently be changed to allow other health practitioners to act in this role.
6. Require the VAD Board to provide independent oversight of the VAD process, by providing prospective approval of applications in addition to the retrospective review of all applications.
7. Include in the Bill (Act) the following requirements regarding palliative care funding:
    a. The Annual Reports prepared by the VAD Board must include information about palliative care spending. This will align with Section 185 of the NSW legislation.
    b. If an Annual Report of the VAD Board indicates a reduction in the amount spent by the ACT on palliative care from the corresponding amount reported in the most recent previous report, the Minister must cause a review of the operation of the Act to be conducted and a

report of the review prepared and submitted to the Minister. This will align with Section 28(2) of the SA legislation.

8. Amend the requirements of the initial three year review to remove the requirement for the Minister to consider expanding the eligibility to include children and young people under 18 years old and people without decision making capacity via advanced care directives.

Recommendation:

- Increase funding for universal access to palliative and end of life care for all people who live in the ACT or live near the ACT and access healthcare services in the ACT.

How this Bill differs from the New South Wales VAD legislation

The Bill represents a notable deviation from the existing VAD legislation in other Australian jurisdictions. Calvary is particularly concerned about the incongruence between the proposed ACT model and the established NSW model. This misalignment is expected to introduce unnecessary complexity and confusion for those individuals accessing and navigating the ACT health system. Calvary submits that addressing and harmonising these legislative differences is imperative to ensure a cohesive and streamlined approach to this issue within the region.

New South Wales VAD Act	Australian Capital Territory VAD Bill
A health establishment, including hospitals and hospices, may choose not to provide VAD services. If an inpatient wants to access VAD, the health care establishment may transfer the patient to another facility where VAD is available.	The Bill does not allow a care facility, including hospitals and hospices, to choose not to provide VAD services. A facility must allow a VAD practitioner to enter the facility to access the person, unless it is not "reasonably practicable."
The roles of coordinating and consulting practitioner can only be filled by a medical practitioner with specialist registration (or general registration held for at least 10 years).	The Bill does not outline who is eligible to act as a coordinating, consulting or administering practitioner. The eligibility requirements for health practitioners to fill these roles will be prescribed by regulation.
A health establishment that does not provide VAD must publish information about the fact that it does not provide VAD services.	A care facility must publish a policy outlining how it complies with the minimum standards. This must be available to prospective and current patients, residents or clients.
The VAD Board provides independent oversight of the VAD process by prospectively approving VAD applications before a substance can be prescribed	The VAD Board will not provide any oversight of the VAD process before the process is complete. It will only provide a retrospective review.
To be eligible, a person must be expected to die within the next six months (or 12 months if the person has a neurodegenerative condition).	There is no requirement for a person's death to be expected within a certain timeframe.
After two years, the Minister must review operations and effectiveness of the Act, taking into account accessibility for people living in regional areas.	After three years, the Minister must review whether VAD should also be available to: • children and young people under 18 years of age; • people without decision-making capacity (via advanced care directives); • people who do not meet the residency requirements.

Response to issues

Obligations on facilities

Although the framework states "facilities may decide their level of involvement with VAD," the Bill contains a number of obligations for entities operating facilities. The explanatory statement interprets a facility's non-provision of VAD as a tension between "the rights of the individual seeking access to VAD" and "the interests of facilities operators."[2]

However, in the ordinary course of delivering healthcare, it is routine and unremarkable for facilities not to provide every service. This may be because the service falls outside the facility's scope of practice or it may be because the facility does not wish to provide certain services. For instance, not all hospitals provide neurosurgical services. It is not considered an unreasonable curtailment of individual rights that a person cannot choose to have a neurosurgical procedure in a hospital that does not provide this service.

This is a recognised and routine aspect of the healthcare system and healthcare facilities are adept at navigating such scenarios as part of daily operations. In situations where a facility does not offer a specific service, established governance structures and procedures are in place to facilitate the seamless transfer of patients to another facility capable of providing the required service. Effectively managing these circumstances is integral to sound clinical governance and constitutes a regular facet of health care delivery, particularly for facilities offering sub-acute services.

The ACT has a plurality of healthcare providers, which in many ways mirrors the diversity of the communities, in both the ACT and NSW, which receive healthcare in the ACT. This plurality of providers is in the best interest of all and eases the burden on the ACT's public healthcare system. Any attempt to oblige facilities to provide services outside their scope of practice is a substantial risk to this approach which is in the public interest and serves the good of all.

Permanent vs non-permanent residents

The Bill overlooks a crucial difference between facilities providing health and care services for non-permanent residents, such as hospitals and hospices, and those primarily serving permanent residents, such as residential aged care facilities. These contexts differ markedly, both in the nature of care provided and the consequent governance requirements.

In hospital or hospice environments, the primary focus is clinical care; whereas in residential aged care, emphasis is placed on the resident's home environment. Consequently, in the former, facility operators bear responsibility for all aspects of clinical care. While in the latter, care providers are accountable for the residential setting as the resident's home and the care services offered by the facility. Beyond this, residents in residential aged care often seek and engage with external healthcare providers for additional healthcare needs.

The existing NSW legislation recognises this nuanced distinction, and Calvary strongly recommend its incorporation into the Bill to mitigate potential confusion. Calvary submits that clarifying these distinctions

[2] Explanatory Statement, 82.

is vital for ensuring that regulatory frameworks align with the diverse operational dynamics of healthcare facilities.

External VAD practitioners in hospitals and hospices

If an individual temporarily residing in a hospital, hospice or other in-patient facility, seeks information about or access to VAD, the Bill mandates the facility operator must permit a relevant person reasonable access to the resident, unless deemed "not reasonably practicable" by the facility operator.[3] This access extends to allowing coordinating, consulting, or administering practitioners to fulfil any formal step in the VAD process, including the administration of a VAD substance, in the facility.

In the context of hospitals and hospices, this represents a significant departure from the obligations of the NSW legislation, eliciting noteworthy concerns regarding the credentialing of health practitioners visiting a facility to provide VAD services to a resident. Expecting a facility operator, which does not provide VAD services at the facility, to credential external health practitioners for these purposes is not reasonable. Nor does it align with good clinical governance standards. The operator of a facility, which does not provide VAD, cannot provide the appropriate standard of quality assurance and review for a service beyond their scope.

Calvary, as a matter of policy, mandates adherence to our Code of Conduct and the accompanying Code of Ethical Standards for all credentialed health practitioners. Consequently, Calvary does not credential external health practitioners to enter Calvary facilities to provide services beyond our expertise, as we could not ensure the appropriate standard of clinical care and quality assurance. This stance reflects our commitment to maintaining the highest standards of care, ethical conduct, and clinical governance within our facilities.

Changes submitted

1. Acknowledge a distinction, in the definitions listed in Clause 96, between facilities which provide services to permanent residents, such as residential aged facilities, and facilities which provide services to non-permanent residents, such as hospitals and hospices.
2. Regarding facilities, such as hospitals and hospices, which provide episodic care and services to exclusively non-permanent residents, align the Bill (Act) with the requirements of Division 3 Health care establishments (Sections 99-107) of the NSW legislation, including the following:
    a. Do not force non-participating facilities to allow external practitioners, who are not credentialed by the facility's operator, to enter the facility and provide VAD services, which are outside the facility's scope of practice. For example, the NSW legislation handles this by requiring the facility operator to take reasonable steps to facilitate the transfer of the person to and from a place where the person may access the formal steps of the VAD process.
    b. Permit non-participating facilities to make decisions about patient transfer in consultation with the treating medical practitioner, e.g. the medical practitioner credentialed by the facility's operator, and taking into account the considerations listed in Clause 101 (3)(a-e)

[3] Clause 100.

of the Bill. This will align the Bill with the existing legislation in NSW.

3. Remove the requirement for the facility operator to provide the person with the contact details for the VAD navigator service *in writing* and align requirements regarding access to information about VAD with Sections 90 and 99 of the NSW legislation.

Eligibility requirements for authorised practitioners

The ACT Government's proposed VAD framework differs from the VAD models in other Australian jurisdictions by allowing either the coordinating practitioner or the consulting practitioner to be a nurse practitioner, with the proviso that the health professional in the other role is a medical practitioner.

However, Calvary is concerned about the absence of eligibility criteria for health practitioners acting in the capacities of coordinating, consulting and administering practitioners within the Bill. Contrary to established practice in other Australian VAD jurisdictions, the Bill defers the definition of eligibility requirements to be prescribed by regulation rather than expressly detailing them. This approach is inadequate, as it falls short of the standard set by other jurisdictions where eligibility criteria are explicitly outlined in the relevant Acts.

Given the comprehensive scope of the term 'health practitioner' as defined in the Health Practitioner Regulation National Law (ACT) Act 2010, encompassing professions like dentistry, chiropractic, and podiatry, it is imperative that the Bill specifically identifies which health practitioners will meet the eligibility criteria. This clarification is essential for maintaining consistency and transparency in the implementation of the VAD framework within the ACT.

Calvary is concerned that the proposed flexibility in the framework will allow the ACT Government to make substantial changes without amending legislation. The Explanatory Statement underscores this flexibility as necessary, citing the possibility that prior requirements might unduly restrict the pool of available health practitioners for VAD assistance.[4] Calvary seeks clarification on which health practitioners, beyond medical and nurse practitioners, the ACT Government envisions authorising as coordinating or consulting practitioners in the future. The roles of coordinating and consulting practitioners demand a significant level of clinical expertise in diagnosis and prognosis.

Notably, no other Australian jurisdiction, including NSW, permits any health practitioner other than a medical practitioner to serve as a coordinating or consulting practitioner. These roles involve critical clinical decisions on an individual's diagnosis, prognosis, and decision-making capacity in relation to VAD—decisions that fall outside the scope of practice for most health practitioners. Expanding eligibility to practitioners, who do not have the requisite scope of practice, solely due to concerns about the size of the practitioner pool, would be inappropriate.

The publicly outlined VAD framework by the ACT Government permits medical practitioners and nurse practitioners to act as coordinating and consulting practitioners.[5] The proposed model specifies that medical practitioners must possess specialist registration and a minimum of one year's practice after specialisation, while nurse practitioners need at least one year of relevant experience post-endorsement.

[4] Explanatory Statement, 78.
[5] ACT Government (2023). "Summary of the ACT framework for voluntary assisted dying," 4.

These requirements must be explicitly included in the Bill.

Similarly, the framework delineates eligibility criteria for administering practitioners. In addition to medical practitioners and nurse practitioners, registered nurses with relevant specialist experience and qualifications may also serve as administering practitioners. This role involves administering a substance to cause immediate death, making it inappropriate to extend this responsibility to health practitioners for whom such a role lies outside their scope of practice.

If the proposed model relies on regulations to define authorised practitioner eligibility, it enables significant changes without the public accountability inherent in the legislative process. The ACT Government should affirm its commitment to the publicly avowed VAD model by clearly detailing eligibility requirements for authorised practitioners within the Bill.

Changes submitted
4. Specify the eligibility requirements for medical practitioners and nurse practitioners to act as authorised coordinating and consulting practitioners in the Bill (Act). This will alleviate concerns that regulations will subsequently be changed to allow other health practitioners to act in these roles. 5. Specify the eligibility requirements for medical practitioners, nurse practitioners and registered nurses to act as authorised administering practitioners. This will alleviate concerns that regulations will subsequently be changed to allow other health practitioners to act in this role.

Governance and role of the VAD Board

We are also concerned the governance framework of the proposed VAD model differs significantly from the NSW model.

The role of the VAD Board in the proposed framework contrasts significantly with the role of the VAD Board in the NSW model and other jurisdictions. Unlike the active role of the NSW VAD Board, which directly oversees the VAD application and approval process by issuing or denying approval before the substance is prescribed, the proposed ACT model introduces a marked shift to a retrospective review process.

In the NSW model, the VAD Board assumes a proactive role, having responsibility for the final approval of applications and the authorisation of VAD substances. In stark contrast, the role of the ACT Board primarily involves monitoring requests and applications, refraining from intervention or decision-making in an individual's VAD process.[6] Consequently, it falls to the coordinating practitioner to grant final approval, assess, and prescribe the approved substances.

This shift intensifies Calvary's existing concerns about the eligibility of health practitioners to act as coordinating and consulting practitioners. Regulatory broadening of eligibility criteria could potentially lead to a workforce which conducts assessments beyond their customary scope of practice, without independent oversight until the process concludes, often with the individual's death. These are serious matters which it is the responsibility of the Legislative Assembly to consider in the interests of good governance, good practice and transparency with all present and prospective stakeholders in the ACT.

[6] Summary of the ACT framework for VAD, 7.

Changes submitted
6. Require the VAD Board to provide independent oversight of the VAD process, by providing prospective approval of applications in addition to the retrospective review of all applications.

A choice without options: palliative care access

The Bill rests upon the premise that a person who is dying should have a variety of palliative and end of life care options available to them. This is clear in the seven principles laid out at the start of the Bill, which includes the principle that:

> "every individual approaching the end of their life should be provided with high quality, person-centred care and treatment, including palliative care, to minimise their suffering and maximise their quality of life."[7]

Other principles include respect for an individual's "autonomy in relation to end of life choices" and that individuals should be supported to make "informed decisions about treatment and end of life choices."[8] The proposed VAD model in this Bill is predicated on the assumption that an individual who wishes to access VAD chooses to do so out of a number of palliative and end-of-life care options available to them.

In order to ensure choice is not just a principle but a reality, high quality palliative and end-of-life care must to be easily accessible to all. We know from experience, in other jurisdictions, that the legalisation of VAD is often accompanied by a temporary increase in palliative care spending. For instance, during the debate over the introduction of VAD in NSW, additional palliative care funding was promised to assist with training of additional professionals in palliative care, in part to assuage the concerns that palliative care was not adequately accessible to provide patients with real choice once VAD was an option. Eighteen months later, shortly before the legislation came into effect, the NSW Government announced it was reducing the palliative care budget by $150 million.

Dr Philip Lee, retired palliative care physician and former director of supportive and palliative medicine at Western Sydney Local Health District, fears that a lack of access to palliative care may cause people who are dying to feel that VAD is their only option.[9]

> *"If you don't have the resources to meet the quality of life needs of palliative care patients, more patients will be requesting voluntary assisted dying." – Dr Philip Lee*

Dr Lee, speaking to the *The Sydney Morning Herald*, said that the budget cuts "will have a dangerous impact on providing quality palliative care services."[10]

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[7] Clause 7(d).
[8] Clause 7(e).
[9] Laura Banks (22 November, 2023), "'I began to lose hope': How 21-year-old Carl beat a deadly prognosis" *The Sydney Morning Herald*, https://www.smh.com.au/national/nsw/i-began-to-lose-hope-how-21-year-old-carl-beat-a-deadly-prognosis-20231120-p5elfz.html
[10] Laura Banks (22 November, 2023), "'I began to lose hope': How 21-year-old Carl beat a deadly prognosis" *The Sydney Morning Herald*, https://www.smh.com.au/national/nsw/i-began-to-lose-hope-how-21-year-old-carl-beat-a-

Not only is funding for universal palliative care access required, but long-term accountability is also required to ensure that palliative care is available to all individuals at the end of their lives.

Change submitted
7. Include in the Bill (Act) the following requirements regarding palliative care funding: a. The Annual Reports prepared by the VAD Board include information about palliative care spending. This will align with Section 185 of the NSW legislation. b. If an Annual Report of the VAD Board indicates a reduction in the amount spent by the ACT on palliative care from the corresponding amount reported in the most recent previous report, the Minister must cause a review of the operation of the Act to be conducted and a report of the review prepared and submitted to the Minister. This will align with Section 28(2) of the SA legislation.
Recommendation
• Fund universal access to palliative and end of life care for all people who live in the ACT or live near the ACT and access healthcare services in the ACT.

Initial review of the Act after three years

The Bill contains a clause that requires the Minister to review the operation and effectiveness of the Act three years after its commencement and every five years thereafter.[11] In the first review, the Minister is required to review whether a person should be able to access VAD if the person:

- Is a child or young person under 18 years old with decision-making capacity in relation to VAD;
- Seeks to access VAD through advanced care planning;
- Has not lived in the ACT for at least the previous 12 months, and is not eligible for an exemption.

The Explanatory Statement notes that "[t]he ACT Government has committed to considering access to VAD for people who have lost decision-making capacity in the future, once the VAD model has been in operation for three years."[12] The explanatory statement describes that the Bill's current requirement for eligible persons to be 18 years or older as limiting "the right to equality and non-discrimination for a young person."[13]

Whilst it is clear the ACT Government intends to widen the eligibility criteria for access to VAD, it is inappropriate for the current ACT Legislative Assembly to bind future parliaments to a particular course of action. A future ACT Government could institute such a process of review if it is minded to do so. This is not a matter to be proscribed in legislation.

Change submitted

deadly-prognosis-20231120-p5elfz.html

[11] Clause 159.

[12] Explanatory Statement, 26.

[13] Explanatory Statement, 18.

8. Amend the requirements of the initial three year review to remove the requirement for the Minister to consider expanding the eligibility to include children and young people under 18 years old and people without decision making capacity via advanced care directives.

Concluding remarks

Again, Calvary thanks the Select Committee for the opportunity to provide feedback on the *Voluntary Assisted Dying Bill 2023* (ACT) and outline our concerns with the VAD model proposed in the Bill.

Should it be required, Calvary is also willing to provide an oral submission to the Committee at any public hearings the Committee may hold.

Please direct any questions you may have to Calvary's National Director of Mission and People, Mark Green.

Appendix: Who we are

In 1885, six courageous Sisters sailed into Sydney to continue the mission of Venerable Mary Potter and the Sisters of the Little Company of Mary to care for those in need.

Thus began Calvary's enduring legacy of care in Australia.

Today, we continue their mission, in our hospitals, home and virtual care services, retirement living and residential aged care homes across five states and two territories.

Calvary has a rich heritage of serving the needs of our communities across each stage of life since 1885.

We are committed to our Mission of "Being for Others", innovating and evolving our Calvary Care System in direct response to those we care for, while challenging the industry as a leader with a passion for caring in the changing landscape of health and ageing.

Calvary is a charitable Catholic not-for-profit organisation with more than 18,000 staff and volunteers, three public hospitals, 10 private hospitals, 17 retirement living villages, 62 residential aged care homes, 17 home care sites and a virtual care service.

Residential aged care

Calvary offers a range of aged care homes across ACT, NSW, Victoria, South Australia, Tasmania and Queensland to provide person-centred care in a supportive environment.

Hospitals

Calvary hospitals provide acute and sub-acute care across ACT, NSW, Victoria, South Australia and Tasmania.

Retirement living

Calvary has increased its retirement living footprint, which respects the freedom to live independently, while often being co-located with an aged care home to make transition to full-time care easier, if required.

Home care

Calvary supports people in their own home through a range of aged care, disability and support services to enable independence, improve social connections and promote positive health and wellbeing.

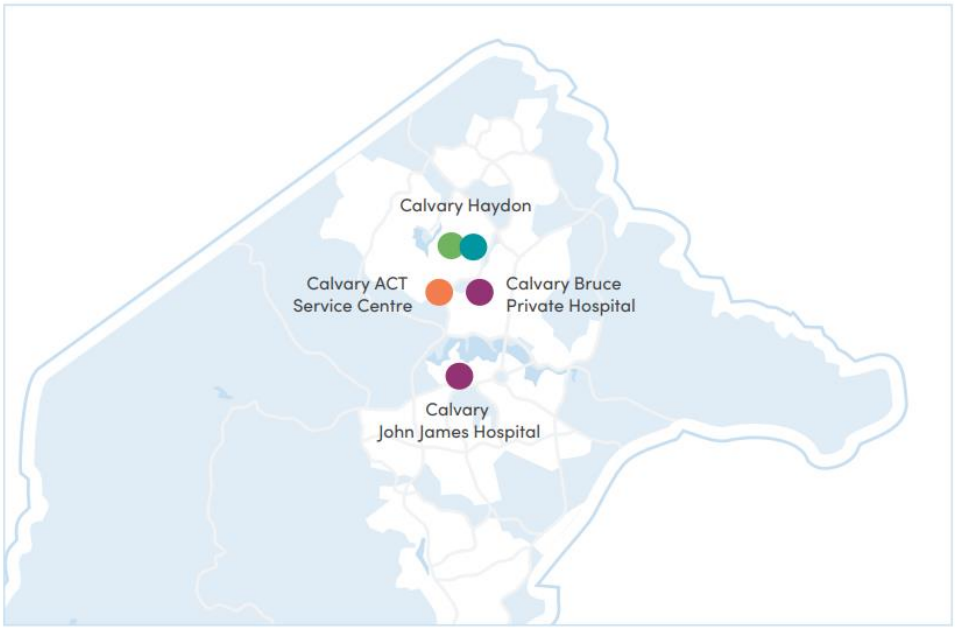
Virtual care

Calvary has developed a virtual care concept allowing some acute conditions to be managed at home with a medical-led digital platform with remote monitoring.

Regional Map

ACT

***AS OF JULY 2023**



ACT

- Calvary ACT Service Centre, Bruce
- Calvary Bruce Private Hospital, Bruce
- Calvary Haydon, Bruce
- Calvary John James Hospital, Deakin

KEY

- Public Hospital (3)
- Private Hospital (11)
- Home Care (17)
- Virtual Care (1)
- Retirement Living (17)
- Residential Aged Care (62)

Regional Map

NSW and QLD

***AS OF JULY 2023**

NSW

- Calvary Albury & District, Glenroy
- Calvary Brighton-Le-Sands, Brighton-Le-Sands
- Calvary Cessnock, Cessnock
- Calvary Chiara Respite Cottage, Lakelands
- Calvary Cooinda, Singleton
- Calvary Corymbia, Belrose
- Calvary Ephesus, Lambton
- Calvary Health Care Kogarah, Kogarah
- Calvary Henley Manor, Doonside
- Calvary Hunter Service Centre, Warrabrook
- Calvary Manning - Taree Service Centre, Taree
- Calvary Mater Newcastle, Waratah
- Calvary Mt Carmel, Maitland
- Calvary Muswellbrook, Muswellbrook
- Calvary Nazareth, Belmont North
- Calvary Riverina Hospital, Wagga Wagga
- Calvary Riverina Service Centre, Wagga Wagga
- Calvary Ryde, Ryde
- Calvary St Francis, Eleebana
- Calvary St Joseph's, Sandgate
- Calvary St Luke's, Cooks Hill
- Calvary St Martin de Porres, Waratah
- Calvary St Paul's, Cundletown
- Calvary Star Of The Sea Respite Cottage, Forster
- Calvary Sydney Service Centre, Beverley Park
- Calvary Tanilba Shores, Tanilba Bay
- Calvary The Brelsford, Coffs Harbour
- Calvary The Mariner, South West Rocks
- Calvary Tours Terrace, Hamilton

QLD

- Calvary Gympie Views, Gympie
- Calvary Noosa, Tewantin
- Calvary Robina Rise, Robina

KEY

- Public Hospital (3)
- Private Hospital (11)
- Home Care (17)
- Virtual Care (1)
- Retirement Living (17)
- Residential Aged Care (62)

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Voluntary Assisted Dying Act 2022 (NSW)

Voluntary Assisted Dying Act 2021 (SA)

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